PREAUTHORIZATION PROCESS AND DOCUMENTATION REQUIRED

Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

SUBMITTING REQUESTS FOR SERVICES

After the individual is successfully enrolled by DMAS and the contractor has the current POC with all identified services, the case manager may begin submitting requests. The contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, dmas.kepro.org. The program will take you through the steps needed to receive approval for service requests.

They may also be reached by phone at:

Telephone: 1-888-VAPAUTH
1-888-827-2884

Fax: 1-877OKBYFAX
1-877-652-9329

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	**Enrolled Individual**	**Comments**
Approval	X	X	
Denial/Partial Denial	X	X	Appeal Rights are included in all denials/partial denials

DMAS will not reimburse providers for dates of service prior to the date identified on the

notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR).

Except when Medicare is the primary payer, when more that five visits are medically necessary, the provider must request preauthorization. When a recipient has Medicare Part B coverage, preauthorization is not required. If Medicare denies the claim, the provider may request authorization as a retrospective review. This is the only time that a retrospective review is allowed, and it must be done within 30 days of the notification of the Medicare denial.

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Preauthorizations are specific to a recipient, a provider, a service code, an established quantity of units, and for specific dates of service. If preauthorization is required, preauthorization must be obtained regardless of whether or not Medicaid is the primary payer.

The following information is required in order to determine if the individual meets criteria: (1) a physician order and nursing plan of treatment or therapy evaluation; (2) verification of medical necessity for the service; and (3) evidence of discharge planning. Preauthorizations are specific to the recipient, provider, service code, and specific dates of service. If a claim for a service requiring preauthorization does not match the authorization, the claim will be pended for review or denied.

In addition, DMAS requires the following for Home Health Services:

- The recipient meets InterQual criteria upon admission and continued stay. These criteria may be obtained through:

  McKesson Health Solutions LLC
  275 Grove Street
  Suite 1-110
  Newton, MA 02466-2273
  Telephone: 800-274-8374

  Fax: 617-273-3777
  Website: mckesson.com or InterQual.com

<u>Subsequent Recertification Review</u>

Prior to the end of the last authorized date, or the next visit, the provider must submit the plan of treatment for continued preauthorization. This plan of treatment will be reviewed to determine if it meets DMAS criteria and documentation requirements found in

Chapters IV and VI of this manual, including the physician's signature and date on the plan of treatment. The DMAS preauthorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the preauthorization contractor will authorize a specific number of units and dates of service based on the plan of treatment.

PRIOR AUTHORIZATION RECONSIDERATIONS and APPEALS PROCESS

Provider Appeals

If services are denied by the preauthorization analyst an automatic reconsideration process will be conducted by a physician reviewer and the provider will be notified of the outcome of the decision.

After completion of the reconsideration process, the denial of pre-authorization for services not yet rendered may be appealed in writing by the Medicaid client by sending a written request for an appeal within 30 days of the receipt of the notice of denial. The client or the client's authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of the denial. The notice is considered filed when it is date stamped by the Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th floor
Richmond, Virginia 23219

Recipient Appeals

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

If the denied intensive rehabilitation service has not been provided, the denial may be appealed by the recipient or by the recipient's authorized representative. For additional information on recipient appeals, refer to the appeals section of Chapter VI of this manual.

Early Periodic Screening Diagnosis and Treatment

Prior Authorization

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the recipient.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905*[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently preauthorized by the PA contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific

item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all pre authorization reviews of prior authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined

by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver recipients may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

Examples of EPSDT review process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

The review process as described is to be applied across all non waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: hearing aids, substance abuse treatment, non waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).